

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-02-18
MEDICAL FEE SCHEDULE**

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0800-02-18-.01 MEDICARE-BASIS FOR SYSTEM, APPLICABILITY, EFFECTIVE DATE AND CODING REFERENCES.

- (1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's ("AMA's") CPT Code Guide, the Health Care Financing Administration Common Procedure Coding System ("HCPCS"), the current and effective AMA's Medicare RBRVS: The Physicians' Guide, the American Society of Anesthesiologists ("ASA") Relative Value Guide, and current effective Medicare procedures and guidelines.
- (2) These Medical Fee Schedule Rules must also be used in conjunction with Medical Cost Containment Program Rules, Chapter 0800-2-17, and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding electronic billing and prompt payment of provider's bills, are adopted by reference as if set forth fully herein.
- (3) These Medical Fee Schedule Rules are effective May 1, 2006 and apply to all services provided on or after May 1, 2006. The most current versions of the American Medical Association's CPT and the Medicare RBRVS shall automatically be applicable and are adopted by these Rules by reference upon their effective dates. Fees shall be calculated using the edition of the CPT and RBRVS effective on the date of service.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008.

0800-02-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.**(1) Format**

- (a) These Rules address and consist of the following sections: General Guidelines, General Medicine (including Evaluation and Management), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Implants and Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Centers and Outpatient Hospital Care, Chiropractic, Ambulance Services and Clinical Psychological Services. Providers should consult and use the section(s) containing the procedure(s) they perform, or the service(s) they render, together with the appropriate sections of the Medical Cost Containment Program Rules, and the In-patient Hospital Fee Schedule Rules, if applicable.

(2) Reimbursement

- (a) Unless otherwise indicated herein, the current, effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the current effective CMS' Medicare allowable amount. The current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the Medical Cost Containment Program Rules at 0800-2-17-.03(80).
- (b) Reimbursement to all providers shall be the lesser of the following:
 - 1. The provider's usual charge;
 - 2. The fee calculated according to the TDWC Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);
 - 3. The MCO/PPO or any other contracted price;
 - 4. In no event shall reimbursement be in excess of these TDWC Fee Schedule Rules, unless otherwise provided in the Division's rules. Reimbursement in excess of the TDWC Medical Fee Schedule Rules may result in civil penalties, at the Administrator's discretion, of up to \$10,000.00 per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. It is recognized that providers must bill all payers at the same amount and simply billing an amount which exceeds the Fee Schedule Rules does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule Rules for longer than ninety (90) calendar days that constitutes a violation by a provider. At the Administrator's discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers' Compensation Act ("Act").

(Rule 0800-02-18, -.02, continued)

5. Any provider reimbursed or carrier paying an amount which is in excess of the maximum amount allowed under these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. If such amount is refunded/recovered within this ninety (90) calendar day time period, the overpayment shall not be considered a violation of these Rules by the provider/carrier and shall not be the basis for a penalty against the provider receiving or carrier paying the excessive payment.
6. The "lesser of" comparison among (1) the provider's usual charge, (2) the maximum allowable amount pursuant to these Rules, or (3) any other contracted amount, should be determined based on the entire bill or amount due for a particular service, rather than on a line-by-line basis.

(3) Fee Schedule Calculations

- (a) The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT code by multiplying the CMS relative value units ("RVUs") by CMS' Tennessee specific Geographic Practice Cost Index ("GPCI") to establish Tennessee specific RVUs, then multiplying the adjusted Tennessee total RVUs by the appropriate Medical Fee Schedule conversion factor. Whether one uses the facility or nonfacility RVUs is determined using the current, effective Medicare guidelines and is dependent upon the location at which the service is provided. Certain specialty areas listed below do not have a specific conversion factor and the maximum reimbursement amount allowed is the usual and customary amount (defined in the Medical Cost Containment Rules at 0800-2-17-.13(80)), as indicated. For areas not listed, the maximum allowable amount is 100% of the Tennessee specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology.
- (4) Practitioner fees shall be based on the conversion factor of 33.9764, which shall be used in conjunction with the most current Medicare RVUs. The Division may designate another baseline conversion factor at any time through the rulemaking process. The Tennessee-specific conversion factors listed below should be applied to the service category in order to calculate the appropriate amount.

Service Category	TN Conversion Factor
Anesthesiology.....	\$75.00 per unit
Orthopaedic and Neurosurgery*	275%
General Surgery.....	200%
Radiology.....	200%
Pathology.....	200%
Physical/Occupational Therapy.....	130%
Chiropractic.....	130%
General Medicine (including evaluation & management).....	160%
Emergency Care.....	200%

(Rule 0800-02-18, -.02, continued)

Dentistry.....100%

* Orthopaedic and neurosurgeons may use the modifier “ON” on the HCFA 1500 form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health’s database may be consulted in order to determine the provider’s specialty.

(5) Forms

- (a) The following forms (or their official replacements) should be used for provider billing: CMS 1500 and UB 92
- (b) Bills for reimbursement shall be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this information to the Providers.

(6) Violations of Fee Schedule Rules and Medical Cost Containment Rules

- (a) The Administrator, Administrator’s Designee, or an agency member appointed by the Administrator, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Medical Cost Containment Program Rules (“Rules”) as prescribed in the Rules. Any party notified of an alleged violation, whether or not they are assessed civil penalties hereunder, shall be entitled to a contested case hearing before the Administrator, Administrator’s Designee, or an agency member appointed by the Administrator pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the Division by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendments filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Emergency rule filed September 2, 2011; effective through February 29, 2012. Withdrawal of emergency rule 0800-02-18(4) filed November 8, 2011 by the Department of Labor and Workforce Development; withdrawal effective November 8, 2011. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-18-.03 GENERAL GUIDELINES.

- (1) Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.
- (2) The Guidelines found in the most current effective editions of the AMA’s CPT Guide and Medicare RBRVS: The Physicians’ Guide apply to the following: General Medicine (includes Evaluation and Management), General Surgery, Neuro-surgery, Orthopedic Surgery, Chiropractic, Physical and Occupational Therapy, Home Health Care, Home Infusion, Ambulatory Surgical Centers and Outpatient Hospital Services, Radiology, Clinical Psychological, and Pathology. CDT-3 Codes of current dental terminology prescribed by the

(Rule 0800-02-18, -.03, continued)

American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association shall be used for all Dentistry services.

- (3) In addition to the Guidelines found in the AMA's CPT and the Medicare RBRVS: The Physicians' Guide, the following Medical Fee Schedule Rule Guidelines also apply. Whenever a conflict exists between these Medical Fee Schedule Rules and any other state fee schedule, rule or regulation, these Rules shall govern.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.04 SURGERY GUIDELINES.

- (1) Multiple Procedures: Maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s). The major procedure shall be determined to be the procedure with the highest Medicare reimbursement.
- (2) Services Rendered by More Than One Physician:
 - (a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.
 - (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Duly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants' reimbursement shall not exceed 100% of the physician assistant fee that would be due under Medicare guidelines, without regard for conversion factors contained in the workers' compensation Medical Fee Schedule.
 - (c) Two Surgeons: For reporting see the most current CPT. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall not exceed 150% of the maximum allowable Fee Schedule amount of the first surgeon and shall be allocated between the surgeons as agreed by them.
- (3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers.
- (4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge, commonly known as a global fee.

(Rule 0800-02-18-.04, continued)

- (5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.05 ANESTHESIA GUIDELINES.

(1) General Information and Instructions.

- (a) The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for anesthesia codes that do not appear in the RBRVS. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist ("CRNA") who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service. To order the Relative Value Guide, write to the American Society of Anesthesiologists, 520 N Northwest Highway; Park Ridge, IL 60068-2573, or call (847) 825-5586.
- (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, maximum reimbursement shall be 90% of the maximum allowable fee for anesthesiologists under these Medical Fee Schedule Rules. No additional payment will be made to any physician supervising the CRNA.
- (c) Whenever anesthesia services are provided by an anesthesiologist or other physician and a CRNA, reimbursement shall never exceed 100% of the maximum amount an anesthesiologist or physician would have been allowed under these Medical Fee Schedule Rules had the anesthesiologist or physician alone performed these services.

(2) Anesthesia Values

- (a) Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value.
- (b) Basic Value: This relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The Basic Value includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the Basic Value for anesthesia is the Basic Value for the procedure with the highest unit value. The Basic Values in units for each anesthesia procedure code are listed in the current ASA Relative Value Guide.
- (c) Time Value: Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of minutes of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The Time Value is converted into units for reimbursement as follows:

(Rule 0800-02-18-.05, continued)

1. Each 15 minutes or any fraction thereof equals one (1) time unit. For example, 71 minutes of anesthesia time would have the following time units: $71/15 = 5$ Time Units.
 2. No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary post-operative supervision.
- (3) Total Anesthesia Value
- (a) The total anesthesia value ("TAV") for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units. The TAV is calculated for the purpose of determining reimbursement.
- (4) Billing
- (a) Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.
- (5) Reimbursement
- (a) Reimbursement for anesthesia services shall not exceed the maximum allowable Medical Fee Schedule amount of \$75.00 per unit.
- (6) Medical Direction Provided by Anesthesiologists
- (a) When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in an appropriately documents extreme emergency situations. Total reimbursement for the nurse anesthetist and the anesthesiologist shall not exceed the maximum amount allowable under the Medical Fee Schedule Rules had the anesthesiologist alone performed the services.
- (7) Anesthesia by Surgeon
- (a) Local Anesthesia

When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.
 - (b) Regional or General Anesthesia
 1. When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.
 - (i) To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.

(Rule 0800-02-18-.05, continued)

- (ii) Reimbursement shall not exceed the maximum amount allowable under these Medical Fee Schedule Rules of \$75.00 per unit.
 - (iii) The operating surgeon must not use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.
- (8) Unlisted Service, Procedure or Unit Value. When an unlisted service or procedure is provided or without specified unit values, the values used shall be substantiated BR.
- (9) Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values. For any procedure or service that is unlisted or without specified unit value, the physician or anesthetist shall establish a unit value consistent in relativity with other unit values shown in the current ASA Relative Value Guide. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., shall be furnished. Sufficient information shall be furnished to identify the problem and the service(s).
- (10) Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.
- (11) Special Supplies. Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, materials provided, and tray supplies shall be listed separately. Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA.
- (12) Separate or Multiple Procedures. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed December 20, 2007; effective March 4, 2008.

0800-02-18-.06 INJECTIONS GUIDELINES.

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782. In cases where multiple drugs are given as one injection, only one administration fee is owed. Surgery procedure codes defined as injections include the administration portion of payment for the medications billed. J Codes are found in the Health Care Financing Administration Common Procedure Coding System ("HCPCS").

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES).

- (1) When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting.

(Rule 0800-02-18-.07, continued)

- (a) For the purpose of the Medical Fee Schedule Rules, “ambulatory surgical center” means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgical center may be a free standing facility or may be attached to a hospital facility. For purposes of workers’ compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.
- (b) The CMS has implemented the Outpatient Prospective Payment System (“OPPS”) under Medicare for reimbursement for hospital outpatient services at most hospitals. All services paid under the new OPPS are classified into groups called Ambulatory Payment Classifications (“APC”). Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC. Current APC Medicare allowable payment amounts and guidelines are available online at: <http://www.cms.hhs.gov/HospitalOutpatientPPS>. The payment rate for each APC group is the basis for determining the maximum total payment to which an ASC or hospital will be entitled.
- (c) Under the Medical Fee Schedule Rules, the OPPS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s); provided, that the major procedure shall be determined to be the procedure with the highest Medicare reimbursement. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures.
- (d) If a claim contains services that result in an APC payment but also contains packaged services, separate payment of the packaged services is not made since the payment is included in the APC. However, charges related to the packaged services are used in setting outlier calculations.
- (e) Reimbursement for all outpatient services is based on the Medicare Ambulatory Payment Classification (“APC”) national unadjusted base rates, which can be obtained from the Centers for Medicare and Medicaid Services. There are no adjustments for wage-price indices and these are not hospital-specific APC rate calculations. Reimbursements for Critical Access Hospitals (“CAH”) are not based on CAH methodology but on the national unadjusted APC base rates as described in the preceding sentence.
- (f) Status indicators used under Medicare should be interpreted using Medicare guidelines with the exception of status indicator “C,” which Medicare does not reimburse for outpatient services, but requires inpatient treatment. Under these Rules, these procedures listed with status indicator “C” performed on an outpatient basis shall be reimbursed, but with the maximum amount being usual & customary, which is 80% of the billed charges, as defined in the Division’s Rule 0800-2-17-.03(80).
- (g) All other outpatient hospital care in all ASCs and all hospitals, including but not limited to observation and emergency room facility fees, shall be calculated in accordance with the most current Medicare rules and procedures applicable to such services and shall

(Rule 0800-02-18-.07, continued)

be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.

- (h) Facility services do not include (the following services may be billed and reimbursed separately from the facility fees, if allowed under current Medicare guidelines, with the exception of implantables, which at the discretion of the facility shall be billed and reimbursed separately in all cases and in all settings unless they are billed and reimbursed as part of a package or bundled charge):
 - 1. Physician services
 - 2. Laboratory Services (including pathology)
 - 3. Radiology services (professional and/or technical components may only be separately reimbursed when not included in APC)
 - 4. Diagnostic procedures not related to the surgical procedure
 - 5. Prosthetic devices
 - 6. Ambulance services
 - 7. Orthotics
 - 8. Implantables
 - 9. DME for use in the patient's home
 - 10. CRNA or Anesthesia Physician Services (supervision of CRNA is included in the facility fee)
 - 11. Take home medications
 - 12. Take home supplies
- (i) For cases involving implantation of medical devices, the facility shall at their discretion for each individual patient case, choose to bill and shall subsequently be reimbursed at either:
 - 1. 150% of the entire Medicare OPPS payment as described above; or
 - 2. 150% of the non-device portion of the APC within the Medicare OPPS payment and separately bill and be reimbursed for implantable medical devices as described under Rule 0800-02-18-.10.
- (j) The listed services and supplies in subsection (1)(h) above shall be reimbursed according to the Medical Fee Schedule Rules, or at the usual and customary amount, as defined in these Rules, for items/services not specifically addressed in the Medical Fee Schedule Rules.
- (k) There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery and are formally admitted to the hospital as an inpatient will be paid according to the In-patient Hospital Fee Schedule Rules, 0800-02-19. All ASCs shall be paid pursuant to this Rule 0800-02-18-.07 regardless of the patient's length of stay.

(Rule 0800-02-18-.07, continued)

- (l) Pre-admission lab and x-ray may be billed separately from the Ambulatory Surgery bill when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule. Pre-admission lab and radiology are not included in the facility fee.
- (m) Facility fees for surgical procedures not listed shall be reimbursed BR with a maximum of the usual and customary rate as defined in the Division's Rule 0800-02-17-.03(80).

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.08 CHIROPRACTIC SERVICES GUIDELINES.

- (1) Charges for chiropractic services shall not exceed 130% of the participating fees prescribed in the Medicare RBRVS System fee schedule. The number of approved visits shall be limited pursuant to any restrictions in Tenn. Code Ann. § 50-6-204. The same procedures for utilization review applicable to physical therapy and occupational therapy services under Rule 0800-02-18-.09(5) below apply to chiropractic services.
- (2) For chiropractic services, an office visit may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider.
- (3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) calendar days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 25% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-17-.10 of the Medical Cost Containment Program Rules.
- (4) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (5) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.09 PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES.

- (1) Reimbursement for all physical and occupational therapy services shall not exceed one hundred thirty percent (130%) of the maximum allowable fees prescribed in the Medicare RBRVS fee schedule, no matter where the services are performed.

(Rule 0800-02-18, -.09, continued)

- (2) For physical therapy and/or occupational therapy, there shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.
- (3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities or therapeutic procedures performed in excess of four (4) modalities, therapeutic procedures, or combination thereof per day per employee. The definitions of modality and therapeutic procedures from the American Medical Association's Current Procedural Terminology (CPT) 2005 edition are applicable.
- (4) For any procedure for which an appropriate Medicare code is not available, such as a Functional Capacity Evaluation or work hardening, the usual and customary charge, as defined in Rule 0800-2-17-.03(80), shall be the maximum amount reimbursable for such services. The current Medicare CPT codes available for Functional Capacity Evaluations are not appropriate for use under the TN Workers' Compensation Medical Fee Schedule, thus, usual and customary is the proper reimbursement methodology for these procedures.
- (5) Whenever physical therapy and/or occupational therapy services exceed twelve (12) visits, such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review agent to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate; provided, that further certifications are not required to be in increments of twelve (12) visits.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendments filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.10 DURABLE MEDICAL EQUIPMENT AND IMPLANT GUIDELINES.

- (1) Reimbursement for durable medical equipment and implants for which billed charges are \$100.00 or less shall be limited to eighty (80%) of billed charges. Durable medical equipment and implants for which billed charges exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implants are in addition to, and shall be billed separately from, all facility and professional service fees. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form or, for hospital reimbursements, a UB 04 form.
 - (a) Quality. The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of

(Rule 0800-02-18-.10, continued)

supplies/equipment. All billing must contain the brand name, model number, and catalog number.

- (b) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). The maximum allowable rental fee for DME is 100% of the Tennessee Medicare allowable amount. If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RR".
- (c) TENs Units. All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units should be accompanied by a copy of the invoice, if available.

1. Rentals

- (i) Include the following supplies:
 - (I) lead wires;
 - (II) two (2) rechargeable batteries;
 - (III) battery charger;
 - (IV) electrodes; and
 - (V) instruction manual and/or audio tape.
- (ii) Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR"
- (iii) Limited to 30 days trial period.

2. Purchase:

- (i) Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
 - (I) Describe the condition and diagnosis that necessitates the use of a TENs unit.
 - (II) Does the patient have any other implants which would affect the performance of the TENs unit or the implanted unit?
 - (III) Was the TENs unit effective for pain control during the trial period?
 - (IV) Was the patient instructed on the proper use of the TENS unit during the trial period?
 - (V) How often does the patient use the TENS unit?
- (ii) The purchase price should include the items below if not already included with the rental:

(Rule 0800-02-18-.10, continued)

- (I) lead wires;
 - (II) two (2) rechargeable batteries; and
 - (III) a battery charger.
 - (iii) Only the first month's rental price shall be credited to purchase price.
 - (iv) Provider shall indicate TENs manufacturer, model name, and serial number.
- (d) Continuous and Passive Motion (Use Code D0540)
- 1. Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.
 - (2) This Rule 0800-02-18-.10 shall not apply to durable medical equipment and medical supplies (other than implants) with applicable Medicare allowable amounts. Such durable medical equipment and medical supplies (other than implants) shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.11 ORTHOTICS AND PROSTHETICS GUIDELINES.

- (1) Orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 330 John Carlyle Street, Suite 200, Alexandria, VA 22314, (571) 431-0876. Orthotics and prosthetics shall be reimbursed up to a maximum of 115% of the Tennessee Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all facility and professional service fees. Supplies and equipment should be coded 99070 if appropriate codes are not available in the HCPCS and the maximum reimbursement shall be the usual and customary amount. Charges should be submitted on a HCFA or CMS 1500 form.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-18-.12 PHARMACY SCHEDULE GUIDELINES.

- (1) The Pharmacy Fee Guideline maximum allowable amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:
 - (a) The provider's usual charge;
 - (b) A negotiated contract or lower amount; or

(Rule 0800-02-18-.12, continued)

- (c) The fees established by the formula for brand-name and generic pharmaceuticals as described in the following subsections.
- (d) Prescribed Medication Services
 - 1. "Drug" has the meaning set out in Tenn. Code Ann. § 63-10-204.
 - 2. Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
 - 3. Carriers may contract with pharmacy benefit managers to process and administer claims for reimbursement of pharmacy services and review the relatedness and appropriateness of prescribed services. Carriers and pharmacists may also negotiate alternative reimbursement schedules and amounts, so long as the reimbursement amount does not exceed the fee schedule amount set out in these Rules.
 - 4. For the purposes of these TWCD Medical Fee Schedule Rules, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written."
- (e) Reimbursement
 - 1. The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:
 - (i) Average Wholesale Price* ("AWP") + \$5.10 filling fee;
 - (ii) the provider's usual charge; or,
 - (iii) a negotiated contractual or other lesser amount.
 - * The Administrator may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Administrator's discretion.
 - 2. Reimbursement to pharmacists or any third-party billing agency or other contracted agent of a pharmacy shall never exceed the maximum amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. The usual and customary charge of the pharmacy for the medication must be included on each bill. A generic drug must be substituted for any brand name drug unless there is no pharmaceutical and bioequivalent drug available, or the prescribing physician indicates that substitutions are prohibited by including the words "Dispense as Written", or "No Substitution Allowed" in the prescriber's own handwriting, along with a statement that the brand name drug is medically necessary. A prescribing physician may also prohibit substitution of generic drugs by oral or electronic communication to the pharmacist so long as the same content is conveyed that is required in a written prescription.
 - (i) A bill or receipt for a prescription drug shall include all of the following:

(Rule 0800-02-18-.12, continued)

- (I) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates "do not label."
- (II) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
- (III) The strength, unless the prescriber indicates "do not label."
- (IV) The quantity dispensed.
- (V) The dosage.
- (VI) The name, address, and federal tax ID# of the pharmacy.
- (VII) The prescription number, if available.
- (VIII) The date dispensed.
- (IX) The name of the prescriber.
- (X) The name of the patient.
- (XI) The price for which the drug was sold to the purchaser.
- (XII) The National Drug Code Number ("NDC Number"), if one is available.
- (ii) The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:
 - (I) Primary reference: Price Alert from Medi-Span, available online at the following web site: www.medi-span.com/Products/index.aspx?id+27.
 - (II) Secondary reference: (for drugs NOT found in PriceAlert) the Red Book from Medical Economics.
- (iii) Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.
- (iv) A compounding fee not to exceed Twenty-five Dollars (\$25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or provider of service other than a physician.
- (v) If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee,

(Rule 0800-02-18-.12, continued)

interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-02-17-.10 of the Medical Cost Containment Program Rules.

- (vi) If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.

(f) "Patent" or 'Proprietary Preparations"

1. "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.
2. Generic substitution as discussed in (e)(2) above applies also to "over-the-counter" preparations.
3. Pharmacists must bill and be reimbursed their usual and customary charge for the "over-the-counter" drug(s).
4. The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.

(g) Dispensing Practitioner

1. Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
2. "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:
 - (i) Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.
 - (ii) An invoice indicating the cost to the dispensing physician of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.
 - (iii) Reimbursement is limited to the lesser of the provider's billed charge or 20 percent above the actual cost to the dispensing physician of the item.

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the

(Rule 0800-02-18-.12, continued)

reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis. The filling fees otherwise provided in these Rules shall be payable when applicable.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-18-.13 AMBULANCE SERVICES GUIDELINES.

- (1) All non-emergency ground and air ambulance service provided to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 72 hours of the service or within three (3) business days.
- (2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheets, shall be submitted with the bill that states the condition that indicates the necessity of the ground and air ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive form of transportation. The service billed shall be supported by the documentation submitted for review.
- (3) Billing shall be submitted to the employer or carrier on a properly completed HCFA or CMS 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA or CMS 1500 form by HCPCS code.
- (4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on may 7, 2012; new effective date August 9, 2012.

0800-02-18-.14 CLINICAL PSYCHOLOGICAL SERVICE GUIDELINES.

- (1) Reimbursement for psychological treatment services by any clinician other than a licensed psychiatrist shall be based on reasonableness and necessity and shall be reimbursed at 100% of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule). Treatment by a licensed psychiatrist shall be reimbursed as any other evaluation and management medical treatment under this Medical Fee Schedule.
- (2) Whenever such psychological treatment services exceed fifteen (15) sessions/visits, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further psychological treatment services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of psychological treatment services after the first fifteen (15) sessions/visits shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional psychological treatment services as is appropriate.

(Rule 0800-02-18-.14, continued)

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).
Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the TDWC Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Administrator's discretion, be subject to civil penalties of up to ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.
- (2) A provider, employer or carrier found in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of assessment of civil penalties. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.
- (3) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Administrator. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator being deemed a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear any matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the Division's Penalty Program Rules, Chapter 0800-2-13, shall apply and be followed in any such contested case hearing.

(Rule 0800-02-18-.15, continued)

- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.